Washington State Department of Social & Health Services

# Employee / Volunteer Personal Incident Report

| DATE OF INCIDENT | TIME OF INCIDENT ☐ AM ☐ PM |
|---|---|
| | |

## PART 1. TO BE COMPLETED BY EMPLOYEE / VOLUNTEER

| 1. NAME (PLEASE PRINT) LAST, FIRST, MI | 2. DATE OF BIRTH | 3. EMPLOYEE'S IDENTIFICATION NUMBER |
|---|---|---|
| | | |

| 4. MAILING ADDRESS | CITY | STATE | ZIP CODE | 5. HOME TELEPHONE NUMBER ( ) |
|---|---|---|---|---|
| | | | | |

| 6. JOB/POSITION TITLE | 7. SHIFT HOURS | 8. WORK DAYS | 9. DAYS OFF |
|---|---|---|---|
| | | | |

| 10. ASSIGNED WORK LOCATION (FACILITY/OFFICE NAME AND ADDRESS) | 11. REGION |
|---|---|
| | |

| 12. EXACT LOCATION OF INCIDENT (BLDG, ROOM, ETC.) | 13. IN TRAVEL STATUS? ☐ Yes ☐ No |
|---|---|
| | |

14. CAUSE OF ACCIDENT **(CHECK ONE)**

☐ Injured by client ☐ Caught between/under ☐ Injured in training session
☐ Lifting client ☐ Slip/trip ☐ Struck by
☐ Lifting object ☐ Repetitive motion ☐ Bitten (animal, insect)
☐ Carrying ☐ Contact heat/cold ☐ Cut by
☐ Push/pull ☐ Motor vehicle accident ☐ Needle stick
☐ Fall ☐ Other (specify):

15. OCCUPATIONAL EXPOSURE

☐ Blood/body fluids
☐ Airborne diseases
☐ Fumes/gas
☐ Chemicals
☐ Other (please specify):

16. RESULTING INJURY **(CHECK ALL THAT APPLY)**

☐ Cut ☐ Burn ☐ Puncture ☐ **No known injury occurred**
☐ Fracture ☐ Bite ☐ Bleeding
☐ Abrasion/scratch ☐ Bruise ☐ Bodily reaction
☐ Sprain/strain ☐ Swelling/redness ☐ Musculoskeletal disorder (i.e., carpal tunnel, tendonitis, etc.)
☐ Other (specify):

17. BODY PART AFFECTED **(CHECK ALL THAT APPLY)**

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| ☐ Head | ☐ Eye | ☐ Shoulder | ☐ Wrist | ☐ Back (upper) | ☐ Ribs | ☐ Hip | ☐ Respiratory tract |
| ☐ Scalp | ☐ Teeth | ☐ Arm (upper) | ☐ Hand | ☐ Back (lower) | ☐ Leg (upper) | ☐ Ankle | ☐ Groin |
| ☐ Face | ☐ Nose | ☐ Arm (lower) | ☐ Finger | ☐ Abdomen | ☐ Leg (lower) | ☐ Foot | ☐ Glasses |
| ☐ Jaw | ☐ Neck | ☐ Elbow | ☐ Thumb | ☐ Chest | ☐ Knee | ☐ Toe | ☐ Artificial appliances |

☐ Other (specify):

18. DETAILED DESCRIPTION OF HOW INCIDENT OCCURRED **(ATTACH ADDITIONAL PAGE(S) IF NECESSARY)**

19. ACTIONS, EVENTS OR CONDITIONS WHICH CONTRIBUTED TO THE INCIDENT **(ATTACH ADDITIONAL PAGE(S) IF NECESSARY)**

20. RECOMMENDATIONS FOR PREVENTION AND FOLLOW-UP. **(ATTACH ADDITIONAL PAGE(S) IF NECESSARY)**

21. TO WHOM DID YOU REPORT THE INCIDENT?

| NAME | PHONE NUMBER ( ) | DATE | TIME ☐ AM ☐ PM |
|---|---|---|---|
| | | | |

22. Do you believe this incident was caused by a client assault? ☐ Yes ☐ No **Additional forms are needed if answered YES.**

Witness Statement, DSHS 03-389
Assault Benefits Program Witness Statement, DSHS 03-389A
Employee Report of Resident/Client Assault (RCW 72.01.045, RCW 74.04.790), DSHS 03-391
Supervisor's Review of Employee Report of Resident/Client Assault, DSHS 03-394

23. NAME OF WITNESS(ES) **(ATTACH ADDITIONAL PAGE(S) IF NECESSARY)** PHONE NUMBER ( )

| 24. EMPLOYEE/VOLUNTEER'S SIGNATURE | DATE | MAIL STOP | WORK PHONE NUMBER ( ) |
|---|---|---|---|
| | | | |

EMPLOYEE'S NAME (PLEASE PRINT)

**PART 2. TO BE COMPLETED BY SUPERVISOR**

| 1. NAME (PLEASE PRINT) | 2. WORK PHONE NUMBER ( ) | 3. MAIL STOP |
|---|---|---|
| | | |

| | YES | NO | NA |
|---|---|---|---|
| 4. Did your investigation support the statements in Part 1? If no, please attach a signed supporting statement | ☐ | ☐ | ☐ |
| 5. Was the employee/volunteer engaged in regular duties when the incident occurred? | ☐ | ☐ | ☐ |
| 6. Was the incident the result of client interaction or contact? | ☐ | ☐ | ☐ |
| 7. Was first aid administered? | ☐ | ☐ | ☐ |
| 8. Was Emergency Medical Response requested? | ☐ | ☐ | ☐ |
| 9. Are lost workdays anticipated as a result of this incident? | ☐ | ☐ | ☐ |
| 10. Was the employee/volunteer exposed to blood or body fluids? Exposed employees must be advised to consult with a medical provider | ☐ | ☐ | ☐ |
| 11. If exposure occurred, was a Post-Exposure Report (DSHS 03-333) submitted? | ☐ | ☐ | ☐ |
| 12. Did the incident occur in the employee's regularly assigned work area? | ☐ | ☐ | ☐ |
| 13. If no, was the employee oriented to the work area prior to incident? | ☐ | ☐ | ☐ |
| 14. Was personal protective equipment utilized? (If no, please explain.) | ☐ | ☐ | ☐ |
| 15. Was lifting assistance and/or personal protective equipment available, was it utilized? (If no, please explain.) | ☐ | ☐ | ☐ |
| 16. Was the employee following DSHS and local organizational standard operating procedures? (If no, please attach a signed supporting documentation) | ☐ | ☐ | ☐ |
| 17. Was the incident the result of an unsafe work environment? | ☐ | ☐ | ☐ |
| 18. Was the incident the result of an unsafe work practice? | ☐ | ☐ | ☐ |

EXPLANATION OF UNSAFE WORK ENVIRONMENT OR UNSAFE WORK PRACTICE. (ATTACH ADDITIONAL PAGE(S) IF NECESSARY.)

19. To prevent future occurrences did you discuss this incident with the injured employee?
☐ Yes ☐ No

WHAT HAS BEEN DONE TO PREVENT A REOCCURRENCE? (ATTACH ADDITIONAL PAGE(S) IF NECESSARY.)

20. SAFETY / CLAIMS REPRESENTATIVE NOTIFIED:
Name:
Date:
Time:

21. WHAT IS THE STATUS OF THE EMPLOYEE?
☐ Permanent Full-Time ☐ Permanent Part-Time ☐ Non-Permanent ☐ On-call
☐ Other (specify):

22. Did the incident require further attention? ☐ Yes ☐ No
PERSON NOTIFIED PHONE NUMBER ( )

23. DATE NOTIFIED

24. SUPERVISOR'S SIGNATURE

25. DATE

**PART 3. TO BE COMPLETED BY SAFETY OFFICER OR REPRESENTATIVE**

| 1. SIGNATURE | 2. DATE | 3. PRINT NAME HERE | 4. TELEPHONE NUMBER ( ) |
|---|---|---|---|
| | | | |

5. SAFETY OFFICER COMMENTS **(ATTACH ADDITIONAL PAGE(S) IF NECESSARY)**

**PART 4. TO BE COMPLETED BY SUPERINTENDENT/ADMINISTRATOR OR DESIGNATED REPRESENTATIVE (IF EMPLOYEE ANSWERS YES TO PART 1, QUESTION 22).**

| 1. CLIENT NUMBER | 2. ENDORSEMENT ☐ Recommend approval ☐ Do not recommend approval |
|---|---|
| | |

| 3. SIGNATURE | 4. DATE |
|---|---|
| | |

**OFFICE OF SAFETY AND RISK MANAGEMENT USE**

**INSTRUCTIONS**

GENERAL INSTRUCTIONS:

**Part 1 - To be completed by employee/volunteer.** Answer all questions as completely as possible. Be sure to include your name and the date of the incident on any additional sheets. Sign and date the form, then submit all copies to your supervisor.

**Part 2 - To be completed by the supervisor.** Interview witnesses and thoroughly investigate the incident immediately upon notification. Answer all questions as completely as possible. In Part II, Question 6, "client" refers to any client of DSHS. If Part 1, Question 22 is "Yes," ensure additional assault addendums are completed prior to forwarding to the safety representative. Be sure to include the employee's name and date of the incident on any additional pages. Sign and date the form and forward it to the safety office or your unit safety representative (person assigned/performing safety related functions).

**Part 3 - To be completed by the safety officer or unit safety representative.** Review the information for completeness. Determine how extensive an investigation or review should be conducted and follow local procedures to conduct an investigation or review of the events resulting in the incident. Sign and date form. If in Part I, Question 22, is answered YES, then submit to the facility/office senior administrator or designee for recommendation. If in Part I, Question 22, is answered NO, then forward copies of form to address located below.

**Part 4 - To be completed by superintendent/administrator or designated representative.** If the employee answered YES to Part 1 Question 22, please review the incident and all documentation in addition to the appropriate RCW (71.01.045 or 74.04.XXX). Complete Part 4 and provide a recommendation as to approval or disapproval of a request for reimbursement under the RCW and have copies of the completed forms then forward copies to the address below.

**DISTRIBUTION:** DSHS institutions must forward the original DSHS 03-133 with all attachments to the local safety office.
DSHS Headquarters and Field Offices will forward the original (keep copy) DSHS 03-133 with all attachments to:

**Office of Safety and Risk Management**
**PO Box 45882**
**Mail Stop: 45882**
**Olympia WA 98504-5882**

**FOR QUESTIONS: Call the Office of Safety and Risk Management at (360) 725-5833.**
**Web site: http://exec.dshs.wa.lcl/safety/default.shtm**

If the employee SUBMITS a Department of Labor and Industries (L&I) “Report of Industrial Injury or Occupational Disease,” forward the original DSHS 03-133 with all attachments, and the original L&I report, to the address above. You must retain copies of all forms for the L&I file kept on site.

If the employee DOES NOT SUBMIT a Department of Labor & Industries (L&I) "Report of Industrial Injury or Occupational Disease" the local Safety Office or safety representative must retain a copy of DSHS 03-133 for a minimum of five (5) years. The original report (DSHS 03-133) needs to be forwarded to the above address.

**Whether the L&I report is submitted or not,** distribute additional copies of the completed DSHS 03-133 to:
Safety Committee or Safety Representative (for local review procedures)
Supervisor
Employee